

		FOR OHF USE					

LL 1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0040006</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Rosewood Care Center of Elgin</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2000</u> to <u>06/30/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>2355Royal Boulevard</u> <u>Elgin</u> <u>60123</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Kane</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(314) 888-9585</u> Fax # () _____		Paid Preparer (Signed) <u>Accountant's Compilation Report Attached</u> _____ (Date) _____ (Print Name and Title) <u>Cindy A. Tefeller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u> (Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>	
IDPA ID Number: _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>03/05/95</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefeller</u> Telephone Number: <u>(618) 465-7717</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Rosewood Care Center of Elgin# 0040006 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>139</u>	Skilled (SNF)	<u>139</u>	<u>50,735</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>139</u>	TOTALS	<u>139</u>	<u>50,735</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>6,598</u>	<u>6,598</u>	8
9	SNF/PED					9
10	ICF	<u>7,936</u>	<u>19,737</u>		<u>27,673</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,936</u>	<u>19,737</u>	<u>6,598</u>	<u>34,271</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 67.55%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 11/04/94

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 11/04/94 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 40 and days of care provided 6,598Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/2001 Fiscal Year: 06/30/2001

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Rosewood Care Center of Elgin

0040006

Report Period Beginning:

07/01/2000

Ending:

06/30/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	212,004	21,815	9,431	243,250		243,250		243,250		1
2	Food Purchase		158,589		158,589		158,589	(2,741)	155,848		2
3	Housekeeping	135,964	26,582		162,546		162,546		162,546		3
4	Laundry	38,829	15,115		53,944		53,944		53,944		4
5	Heat and Other Utilities			138,845	138,845		138,845	226	139,071		5
6	Maintenance	23,532	6,173	85,328	115,033		115,033	20,656	135,689		6
7	Other (specify):* Sanitation			22,009	22,009		22,009		22,009		7
8	TOTAL General Services	410,329	228,274	255,613	894,216		894,216	18,141	912,357		8
	B. Health Care and Programs										
9	Medical Director			25,201	25,201		25,201		25,201		9
10	Nursing and Medical Records	1,835,039	157,206	100,287	2,092,532		2,092,532		2,092,532		10
10a	Therapy	49,700	2,263	335,081	387,044		387,044	50,591	437,635		10a
11	Activities	43,509	4,771	2,378	50,658		50,658		50,658		11
12	Social Services	48,502		2,394	50,896		50,896		50,896		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,976,750	164,240	465,341	2,606,331		2,606,331	50,591	2,656,922		16
	C. General Administration										
17	Administrative			374,508	374,508		374,508	(247,699)	126,809		17
18	Directors Fees										18
19	Professional Services			6,438	6,438		6,438	40,294	46,732		19
20	Dues, Fees, Subscriptions & Promotions			32,085	32,085		32,085	(7,118)	24,967		20
21	Clerical & General Office Expenses	159,573	28,165	21,845	209,583		209,583	149,353	358,936		21
22	Employee Benefits & Payroll Taxes			328,203	328,203		328,203	33,232	361,435		22
23	Inservice Training & Education										23
24	Travel and Seminar			637	637		637		637		24
25	Other Admin. Staff Transportation			7,836	7,836		7,836	38,210	46,046		25
26	Insurance-Prop.Liab.Malpractice			39,523	39,523		39,523	5,086	44,609		26
27	Other (specify):*										27
28	TOTAL General Administration	159,573	28,165	811,075	998,813		998,813	11,358	1,010,171		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,546,652	420,679	1,532,029	4,499,360		4,499,360	80,090	4,579,450		29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number

Rosewood Care Center of Elgin

#0040006

Report Period Beginning:

07/01/2000

Ending:

06/30/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			7,359	7,359		7,359	232,552	239,911			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			60,329	60,329		60,329	600,621	660,950			32
33	Real Estate Taxes			89,098	89,098		89,098		89,098			33
34	Rent-Facility & Grounds			1,248,194	1,248,194		1,248,194	(1,234,467)	13,727			34
35	Rent-Equipment & Vehicles			6,964	6,964		6,964		6,964			35
36	Other (specify):*											36
37	TOTAL Ownership			1,411,944	1,411,944		1,411,944	(401,294)	1,010,650			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		163,231	14,831	178,062		178,062	(1,249)	176,813			39
40	Barber and Beauty Shops			11,835	11,835		11,835		11,835			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,103	76,103		76,103		76,103			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		163,231	102,769	266,000		266,000	(1,249)	264,751			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,546,652	583,910	3,046,742	6,177,304		6,177,304	(322,453)	5,854,851			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **Rosewood Care Center of Elgin**

0040006

Report Period Beginning:

07/01/2000

Ending:

06/30/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,289)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(17,640)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,249)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(452)	2		13
14	Non-Care Related Interest	(60,329)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,355)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,571)	20		28
29	Other-Attach Schedule Marketing Salary	(67,949)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (157,834)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(164,619)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (164,619)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (322,453)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center of Elgin

ID# 0040006

Report Period Beginning: 07/01/2000

Ending: 06/30/2001

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Marketing Salary	\$ (67,949)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(67,949)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center of Elgin

0040006

Report Period Beginning:

07/01/2000

Ending:

06/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,741)	0	0	0	0	0	0	0	0	0	0	(2,741)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	226	0	0	0	0	0	0	0	0	226	5
6	Maintenance	0	0	20,656	0	0	0	0	0	0	0	0	20,656	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,741)	0	20,882	0	0	0	0	0	0	0	0	18,141	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	50,591	0	0	0	0	0	0	0	0	0	50,591	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	50,591	0	0	0	0	0	0	0	0	0	50,591	16
	C. General Administration													
17	Administrative	0	(374,508)	126,809	0	0	0	0	0	0	0	0	(247,699)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,119	39,175	0	0	0	0	0	0	0	0	40,294	19
20	Fees, Subscriptions & Promotions	(7,926)	0	808	0	0	0	0	0	0	0	0	(7,118)	20
21	Clerical & General Office Expenses	(67,949)	392	216,910	0	0	0	0	0	0	0	0	149,353	21
22	Employee Benefits & Payroll Taxes	0	0	33,232	0	0	0	0	0	0	0	0	33,232	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	38,210	0	0	0	0	0	0	0	0	38,210	25
26	Insurance-Prop.Liab.Malpractice	0	0	5,086	0	0	0	0	0	0	0	0	5,086	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(75,875)	(372,997)	460,230	0	0	0	0	0	0	0	0	11,358	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(78,616)	(322,406)	481,112	0	0	0	0	0	0	0	0	80,090	29

Summary B

Facility Name & ID Number	Rosewood Care Center of Elgin	#	0040006	Report Period Beginning:	07/01/2000	Ending:	06/30/2001
--------------------------------------	--------------------------------------	----------	----------------	---------------------------------	-------------------	----------------	-------------------

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Rosewood Care Center of Elgin# 0040006Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75.00%	See Attached List		See Attached List		
Darrell Hoefling	25.00%	See Attached List		See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management Fee	\$ 374,508	HSM Management Services, Inc.	100.00%	\$	\$ (374,508)	1
2	V							2
3	V	10a Therapy	335,081	Rosewood Therapy Services, Inc.	0.00%	385,672	50,591	3
4	V							4
5	V	34 Rent	1,248,194	Elgin Real Estate LLC	0.00%		(1,248,194)	5
6	V	30 Depreciation		Elgin Real Estate LLC		206,907	206,907	6
7	V	32 Interest		Elgin Real Estate LLC		662,522	662,522	7
8	V	32 Amortization-Loan Fee Expense		Elgin Real Estate LLC		16,068	16,068	8
9	V	19 Professional Fees		Elgin Real Estate LLC		1,119	1,119	9
10	V	21 Office Expense		Elgin Real Estate LLC		392	392	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,957,783			\$ 1,272,680	\$ * (685,103)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin# 0040006Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 See Schedule VIII	\$	HSM Management Services Inc.	100.00%	\$ 126,809	\$ 126,809	15
16	V	21 See Schedule VIII		HSM Management Services Inc.	100.00%	216,910	216,910	16
17	V	22 See Schedule VIII		HSM Management Services Inc.	100.00%	33,232	33,232	17
18	V	25 See Schedule VIII		HSM Management Services Inc.	100.00%	38,210	38,210	18
19	V	30 See Schedule VIII		HSM Management Services Inc.	100.00%	25,645	25,645	19
20	V	34 See Schedule VIII		HSM Management Services Inc.	100.00%	13,727	13,727	20
21	V	19 See Schedule VIII		HSM Management Services Inc.	100.00%	39,175	39,175	21
22	V	26 See Schedule VIII		HSM Management Services Inc.	100.00%	5,086	5,086	22
23	V	6 See Schedule VIII		HSM Management Services Inc.	100.00%	20,656	20,656	23
24	V	5 See Schedule VIII		HSM Management Services Inc.	100.00%	226	226	24
25	V	20 See Schedule VIII		HSM Management Services Inc.	100.00%	808	808	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 520,484	\$ * 520,484	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Rosewood Care Center of Elgin # 0040006 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Vander Maten	President	Management	75.00%	733,684	3	6.87%	Salary	\$ 43,808	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	217,895	3	6.87%	Salary	14,603	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 58,411		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin # 0040006 Report Period Beginning: 07/01/2000 Ending: 6/30/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HSM Management Services, Inc.
 Street Address 11701 Borman Drive, Suite 315
 City / State / Zip Code St. Louis, MO 63146
 Phone Number (314) 994-9070
 Fax Number (314) 994-9912

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 Salaries - Officers	Total Cost	75,137,033	17	\$ 849,990	\$ 849,990	5,163,359	\$ 58,411	1
2	21 Salaries - Others	Total Cost	75,137,033	17	2,658,369	2,658,369	5,163,359	182,681	2
3	22 Payroll Taxes	Total Cost	75,137,033	17	282,151		5,163,359	19,389	3
4	22 Employee Benefits	Total Cost	75,137,033	17	140,469		5,163,359	9,653	4
5	25 Travel	Total Cost	75,137,033	17	180,072		5,163,359	12,374	5
6	30 Depreciation	Total Cost	75,137,033	17	351,550		5,163,359	24,158	6
7	34 Building Rent	Total Cost	75,137,033	17	199,753		5,163,359	13,727	7
8	19 Professional Services	Total Cost	75,137,033	17	570,072		5,163,359	39,175	8
9	21 Telephone	Total Cost	75,137,033	17	200,687		5,163,359	13,791	9
10	26 Insurance	Total Cost	75,137,033	17	74,012		5,163,359	5,086	10
11	21 Taxes & Licenses	Total Cost	75,137,033	17	11,527		5,163,359	792	11
12	21 Office Supplies	Total Cost	75,137,033	17	285,895		5,163,359	19,646	12
13	6 Maintenance	Total Cost	75,137,033	17	300,583		5,163,359	20,656	13
14	5 Heat & Other Utilities	Total Cost	75,137,033	17	3,293		5,163,359	226	14
15	20 Dues & Subscriptions	Total Cost	75,137,033	17	11,759		5,163,359	808	15
16	17 Direct - Admin	Direct Cost	1	1	68,398	68,398	1	68,398	16
17	17 Direct - Admin	Direct Cost	16	16	846,496	846,496	0	0	17
18	22 Direct - Payroll Taxes	Direct Cost	1	1	4,190		1	4,190	18
19	22 Direct - Payroll Taxes	Direct Cost	16	16	51,228		0	0	19
20	30 Direct - Depreciation	Direct Cost	1	1	1,487		1	1,487	20
21	30 Direct - Depreciation	Direct Cost	16	16	26,201		0	0	21
22	25 Direct - Travel	Direct Cost	1	1	25,836		1	25,836	22
23	25 Direct - Travel	Direct Cost	16	16	113,366		0	0	23
24									24
25	TOTALS				\$ 7,257,384	\$ 4,423,253		\$ 520,484	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Bank of America		X	Mortgage Refinanced		3/1999	\$ 10,500,000	\$ 9,789,574	3/2006	PRM+1/2	\$ 681,463	1	
2	Less:Related Party Interest Income Offset										(18,941)	2	
3	Amortization of Loan Fees										16,068	3	
4	Interest Income										(17,640)	4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 10,500,000	\$ 9,789,574			\$ 660,950	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 10,500,000	\$ 9,789,574			\$ 660,950	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Rosewood Care Center of Elgin**# **0040006** Report Period Beginning: **07/01/2000** Ending: **06/30/2001****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2000 report.			\$ 89,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$ 88,273	2
3. Under or (over) accrual (line 2 minus line 1).			\$ (1,127)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 90,225	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 89,098	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1996	81,549	8	
	1997	81,132	9	
	1998	82,519	10	
	1999	87,214	11	
	2000	89,332	12	
1999 Payment \$43,607				
2000 Payment \$44,666				
Accrual = 2000 Remaining (44,666) +1/2 of Estimated 2001 Tax Bill (45,559)				
				FOR OHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2000	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center of Elgin COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0040006

CONTACT PERSON REGARDING THIS REPORT Lou Netemeyer

TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-09-100-021</u>	<u>02355 Royal</u>	\$ <u>89,331.98</u>	\$ <u>89,331.98</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>89,331.98</u>	\$ <u>89,331.98</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:
 43,268
 B. General Construction Type:
 Exterior
 Brick
 Frame
 Wood
 Number of Stories
 1

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☐ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	206,817	1993	\$ 590,758	1
2					2
3	TOTALS	206,817		\$ 590,758	3

Facility Name & ID Number Rosewood Care Center of Elgin

0040006

Report Period Beginning:

07/01/2000

Ending:

06/30/2001

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	139			1994	\$ 4,829,673	\$	25-40	\$ 128,067	\$ 128,067	\$ 853,779	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			1996	4,792		25	192	192	1,056	9
10	Hot Water Booster			1994	661		10	66	66	440	10
11	Building Sign			1994	1,827		10	183	183	1,220	11
12	Walk-In Cooler			1994	5,231		10	523	523	3,487	12
13	Salad Prep Sink			1994	1,966		10	197	197	1,313	13
14	Exhaust Hood			1994	7,104		10	710	710	4,733	14
15	Worktable with Sink			1994	1,003		10	100	100	667	15
16	Pot & Pan Sink			1994	3,053		10	305	305	2,033	16
17	Signage			1994	5,796		10	579	579	3,860	17
18	Addition to Phone System			1994	3,218		10	321	321	2,140	18
19	Interior Signs			1994	7,506		10	751	751	5,007	19
20	Windowsills/Panels			1994	818		10	82	82	547	20
21	Water Heaters			1994	3,162		10	316	316	2,107	21
22	Water Heater			1994	1,283		10	128	128	853	22
23	Emergency Generator			1994	27,491		10	2,749	2,749	18,327	23
24	Carpet			1994	7,303		10	730	730	4,867	24
25	Wallpaper/Painting			1994	76,500		10	7,650	7,650	51,000	25
26	Telephone			1994	7,550		10	755	755	5,033	26
27											27
28	Leasehold Improvements - Facility:										28
29	Painting			1998	16,105	2,300	7	2,300		6,778	29
30	Door Repairs			1998	4,778	683	7	683		1,878	30
31	Mini Blinds/Wallcovering/Wallpaper			1999	6,187	884	7	884		1,868	31
32	Carpeting			1999	10,413	1,487	7	1,487		2,882	32
33	Drapes			2000	10,234	1,462	7	1,462		1,828	33
34	Computer Cabling			2000	2,392	200	7	200		200	34
35	Dialysis			2000	2,398	343	7	343		343	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Leaschold Improvements - Management Company:		\$	\$		\$	\$	\$	37
38 Office Construction/Improvements	1995	526		5			526	38
39 Office Design	1995	47		5			47	39
40 Office Shelving	1996	112		4			112	40
41 Office Expansion	1996	497		4			497	41
42 Office Expansion	1997	1,330		3			1,330	42
43 Office Expansion	1998	750		3	250	250	695	43
44 Office Addition	1999	371		3	123	123	247	44
45 Door Locks	1999	185		3	62	62	98	45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 5,052,262	\$ 7,359		\$ 152,198	\$ 144,839	\$ 981,798	70

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 691,574	\$	\$ 74,199	\$ 74,199	5-7 Yrs	\$ 443,665	71
72	Current Year Purchases	28,906		2,902	2,902	5-7 Yrs	2,902	72
73	Fully Depreciated Assets	25,673					25,673	73
74								74
75	TOTALS	\$ 746,153	\$	\$ 77,101	\$ 77,101		\$ 472,240	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSM Management	Various	Various	\$ 41,541	\$	\$ 10,612	\$ 10,612	4 Yrs	\$ 24,886	76
77										77
78										78
79										79
80	TOTALS			\$ 41,541	\$	\$ 10,612	\$ 10,612		\$ 24,886	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,430,714	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 7,359	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 239,911	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 232,552	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,478,924	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$ _____

13. /2003 \$ _____

14. /2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO N/A - ONLY HIRE CERTIFIED AIDES If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-8	hrs	\$	21,709	\$ 152,887	\$	21,709	\$ 152,887	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		5,143	48,887		5,143	48,887	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		25,226	183,898	2,263	25,226	186,161	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				134,663		134,663	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Laboratory, Ambulance, X-Ray, Enterals Other (specify): & Specialty Beds	39-8				13,582	28,568		42,150	13
14	TOTAL			\$	52,078	\$ 399,254	\$ 165,494	52,078	\$ 564,748	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 407,763	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 85,000)	1,117,512		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,296		6
7	Other Prepaid Expenses	33,922		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,574,493	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	52,506		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(15,777)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 36,729	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,611,222	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 257,167	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	788,105		29
30	Accrued Salaries Payable	247,846		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,999		31
32	Accrued Real Estate Taxes(Sch.IX-B)	90,225		32
33	Accrued Interest Payable	35,961		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	81,850		36
37	Accrued Rent	24,523		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,538,676	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,538,676	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 72,546	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,611,222	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 62,487	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 62,487	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	46,659	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(36,600)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 10,059	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 72,546	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,299,106	1
2	Discounts and Allowances for all Levels	(1,461,484)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,837,622	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,379,575	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,379,575	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	14,671	13
14	Non-Patient Meals	2,289	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 16,960	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17,640	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,640	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Lab Discounts	1,249	28
28a	Miscellaneous Income	1,717	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,966	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,254,763	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	894,216	31
32	Health Care	2,606,331	32
33	General Administration	998,813	33
	B. Capital Expense		
34	Ownership	1,411,944	34
	C. Ancillary Expense		
35	Special Cost Centers	189,897	35
36	Provider Participation Fee	76,103	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,177,304	40
41	Income before Income Taxes (line 30 minus line 40)**	77,459	41
42	Income Taxes	(30,800)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 46,659	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Rosewood Care Center of Elgin# 0040006Report Period Beginning: 07/01/2000Ending: 06/30/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,632	1,713	\$ 53,552	\$ 31.26	1
2	Assistant Director of Nursing	1,822	1,912	45,090	23.58	2
3	Registered Nurses	32,253	33,842	737,633	21.80	3
4	Licensed Practical Nurses	7,705	8,085	149,160	18.45	4
5	Nurse Aides & Orderlies	67,090	70,396	809,762	11.50	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,555	2,681	49,700	18.54	8
9	Activity Director					9
10	Activity Assistants	4,612	4,839	43,509	8.99	10
11	Social Service Workers	3,597	3,775	48,502	12.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,993	24,126	212,004	8.79	15
16	Dishwashers					16
17	Maintenance Workers	2,291	2,404	23,532	9.79	17
18	Housekeepers	15,173	15,921	135,964	8.54	18
19	Laundry	5,143	5,396	38,829	7.20	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,002	13,642	159,573	11.70	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,920	3,064	39,842	13.00	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	182,788	191,796	\$ 2,546,652 *	\$ 13.28	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	375	\$ 9,431	1-3	35
36	Medical Director	Contract	25,201	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	130	2,378	11-3	44
45	Social Service Consultant	120	2,394	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	625	\$ 39,404		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	3,542	60,217	10-3	51
52	Nurse Aides	4,452	40,070	10-3	52
53	TOTAL (lines 50 - 52)	7,994	\$ 100,287		53

SEE ACCOUNTANTS' COMPILATION REPORT

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
M. Burnell	Administrator	0.00%	\$ 24,876	Workers' Compensation Insurance	\$	80,661	IDPH License Fee	\$ 14,968
K. Fogel	Administrator	0.00%	43,522	Unemployment Compensation Insurance		39,228	Advertising: Employee Recruitment	14,968
				FICA Taxes		192,372	Health Care Worker Background Check	
				Employee Health Insurance		8,810	(Indicate # of checks performed <u>96</u>)	1,354
				Employee Meals			Promotional Advertising	4,925
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Dues/Subscriptions	7,837
				Management Company Allocations		33,232	Management Company Allocations	808
Total Direct Administrator Cost from HSM Mgmt - Line 17, col 7				Employee Physicals		1,260		
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Uniforms		1,682		
(List each licensed administrator separately.)			\$ 68,398	Tuition Reimbursement		1,412		
B. Administrative - Other				Employee Relations		2,778		
							Less: Public Relations Expense	(247)
Description			Amount				Non-allowable advertising	(1,107)
Management Fee			\$ 374,508				Yellow page advertising	(3,571)
				TOTAL (agree to Schedule V,	\$	361,435	TOTAL (agree to Sch. V,	\$ 24,967
				line 22, col.8)			line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 374,508	E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				to Owners or Employees			Description	Amount
C. Professional Services				Description	Line #	Amount		
Vendor/Payee	Type		Amount	Section Not Applicable		\$	Out-of-State Travel	\$
C.J. Schlosser & Company	Accountant/Consultant		6,438					
							In-State Travel	
							Seminar Expense	637
							Entertainment Expense	()
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	line 24, col. 8)	\$ 637
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 6,438					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2		3		4		5		6		7		8		9		10		11		12		13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year																				
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006												
1	Section Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
2																									
3																									
4																									
5																									
6																									
7																									
8																									
9																									
10																									
11																									
12																									
13																									
14																									
15																									
16																									
17																									
18																									
19																									
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Elgin

STATE OF ILLINOIS

0040006

Report Period Beginning: 07/01/2000

Page 23

Ending: 06/30/2001

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 61,355 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 76,103
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,289
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. No Facility specific audit report
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.